Building Capacity: A Framework for Serving Albertans Affected by Addiction and Mental Health Issues

SUMMARY REPORT OF THE CONCURRENT DISORDERS DEMONSTRATION PROJECT EVALUATIONS

September 2006

AADAC Alberta Alcohol and Drug Abuse Commission
An Agency of the Government of Alberta

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PREPARED BY

Alberta Alcohol and Drug Abuse Commission (AADAC)

AADAC Research Services
Komali Naidoo

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Introduction

One of the strategic directions of the Provincial Mental Health Plan for Alberta is increasing service delivery system capacity to respond to the needs of people with concurrent disorders. People with concurrent disorders are defined as "those people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drug."[1]

In the plan, the Alberta Alcohol and Drug Abuse Commission (AADAC) was identified as taking the lead in working directly with health regions and other key stakeholders to develop a provincial strategy for addressing the needs of this population. This provincial framework for collaborative service delivery was built on a review of existing models and approaches, and input from a variety of stakeholders, as well as national and international sources of best practice knowledge and research. The resulting provincial framework is documented in the report entitled Building Capacity—A Framework for Serving Albertans Affected by Addiction and Mental Health Issues.[2] This report (hereinafter referred to as "the framework" or "the provincial framework") proposes a collaborative systems approach to support Albertans whose lives are affected by concurrent addiction and mental health issues.

This service delivery model is designed to be dynamic so that clients can enter the system at any point, with flexibility to move easily between services as their needs change. In addition, the collaborative care model is characterized by services that complement the client's strengths and informal support systems, and that address client needs in a co-ordinated and continuous manner to ensure that the client can move easily between service providers.

The concurrent disorders demonstration projects

In early 2005, two sites were identified as leaders beginning to address concurrent mental health and addictions issues with clients. These sites were asked to implement a demonstration project to examine the collaborative care delivery model by incorporating some or all of the service delivery building blocks, principles, characteristics and concepts described in the framework document.

One demonstration project was located in Edmonton and involved AADAC Adult Counselling and Prevention Services (ACAPS) and Capital Health, Regional Mental Health Program, Edmonton Mental Health Clinic. The purpose of the Edmonton demonstration project was to improve service

[1] Health Canada. (2001). Best practices: Concurrent mental health and substance use disorders. Ottawa, ON: Author, p. 7.

[2] Alberta Alcohol and Drug Abuse Commission. (2005). Building capacity — A framework for serving Albertans affected by addiction and mental health issues. Edmonton, AB: Author.

delivery to clients with concurrent disorders through an initial screening and referral process, shared client consent, and case management. A peer consultation service offered between AADAC and the Edmonton Mental Health Clinic was an important aspect of the Edmonton project.

The second demonstration project was in Fort McMurray and involved the Fort McMurray AADAC Area Office and Northern Lights Regional Health Centre, Mental Health Services, Children's Team. This project also included schools and Family–School Liaison Workers as key partners. The purpose of the Fort McMurray project was to improve the services for youth and their families through enhanced access to co-ordinated and comprehensive services.

Both projects explored enhanced relationships between AADAC and mental health services. Screening and referral processes were developed at each site, along with training and professional development opportunities to build capacity for appropriate identification of concurrent disorders and staff competency to provide services to this population.

Each demonstration project developed flow charts that reflect collaborative care service provision and referral between addictions and mental health services (refer to the figures below). These flow charts visually assist in explaining how collaborative care models work. They also illustrate how clients with concurrent disorders move through the system of care, and indicate where addictions and mental health service providers interrelate.

FIGURE 1: AADAC's Collaborative Model (Edmonton Demonstration Project)

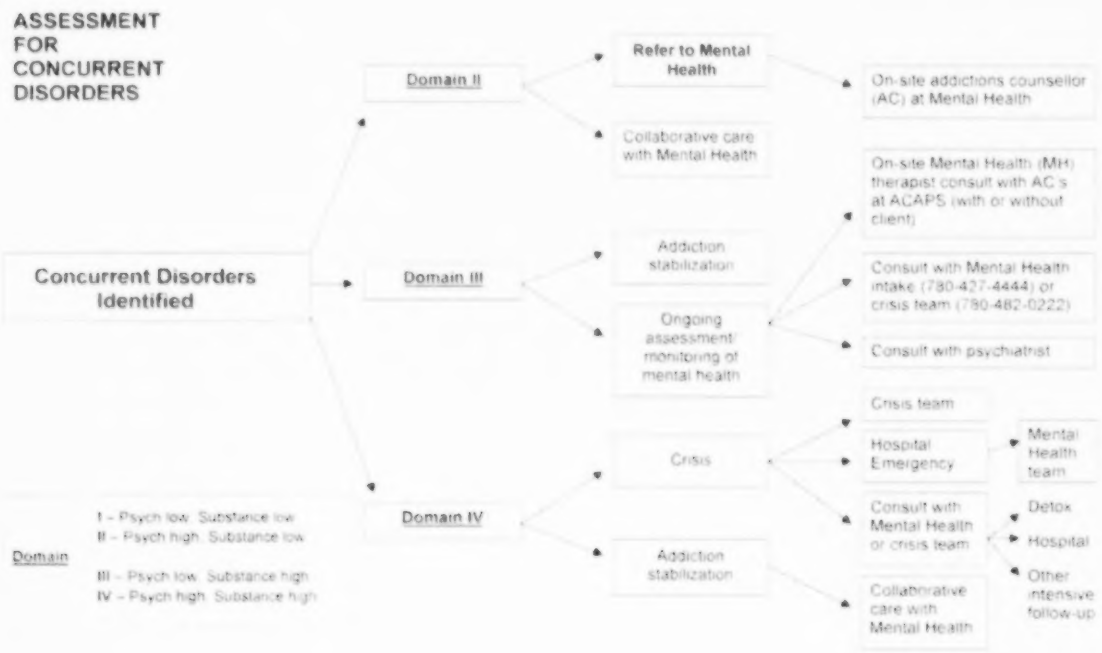

ASSESSMENT FOR CONCURRENT DISORDERS
Concurrent Disorders Identified
Domain II
Refer to Mental Health
On-site addictions counsellor (AC) at Mental Health
Collaborative care with Mental Health
Domain III
Addiction stabilization
On-site Mental Health (MH) therapist consult with AC's at ACAPS (with or without client)
Ongoing assessment monitoring of mental health
Consult with Mental Health intake (780-427-4444) or crisis team (780-482-0222)
Consult with psychiatrist
Domain IV
Crisis
Crisis team
Hospital Emergency
Mental Health team
Consult with Mental Health or crisis team
Detox
Hospital
Other intensive follow-up
Addiction stabilization
Collaborative care with Mental Health
Domain
I – Psych low, Substance low
II – Psych high, Substance low
III – Psych low, Substance high
IV – Psych high, Substance high

FIGURE 2: Mental Health's Collaborative Model (Edmonton Demonstration Project)

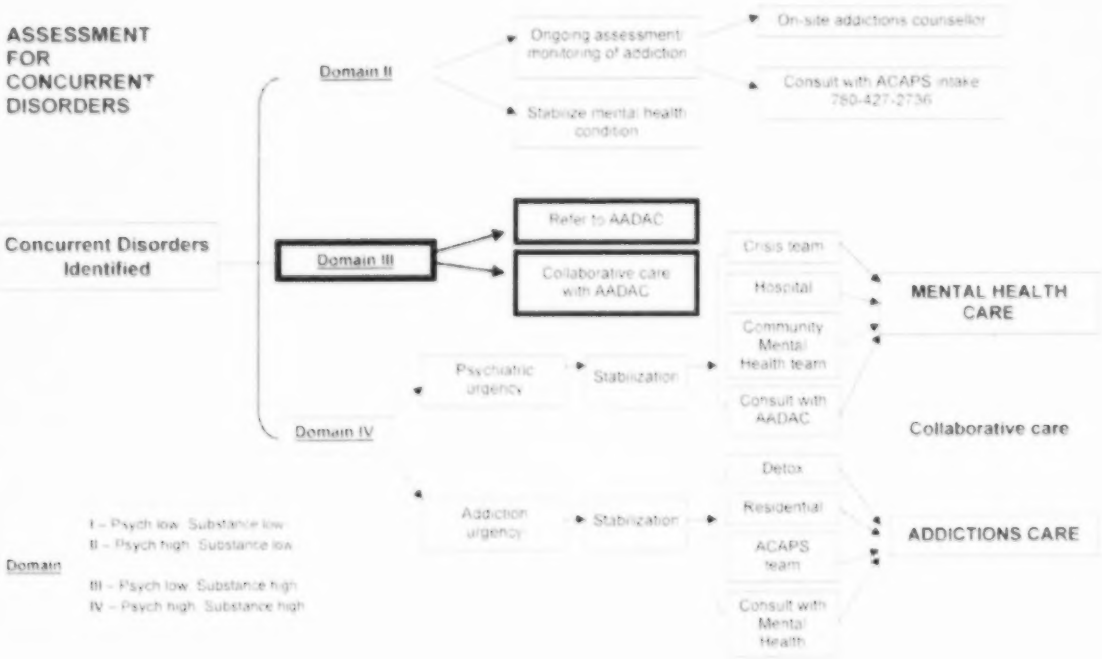
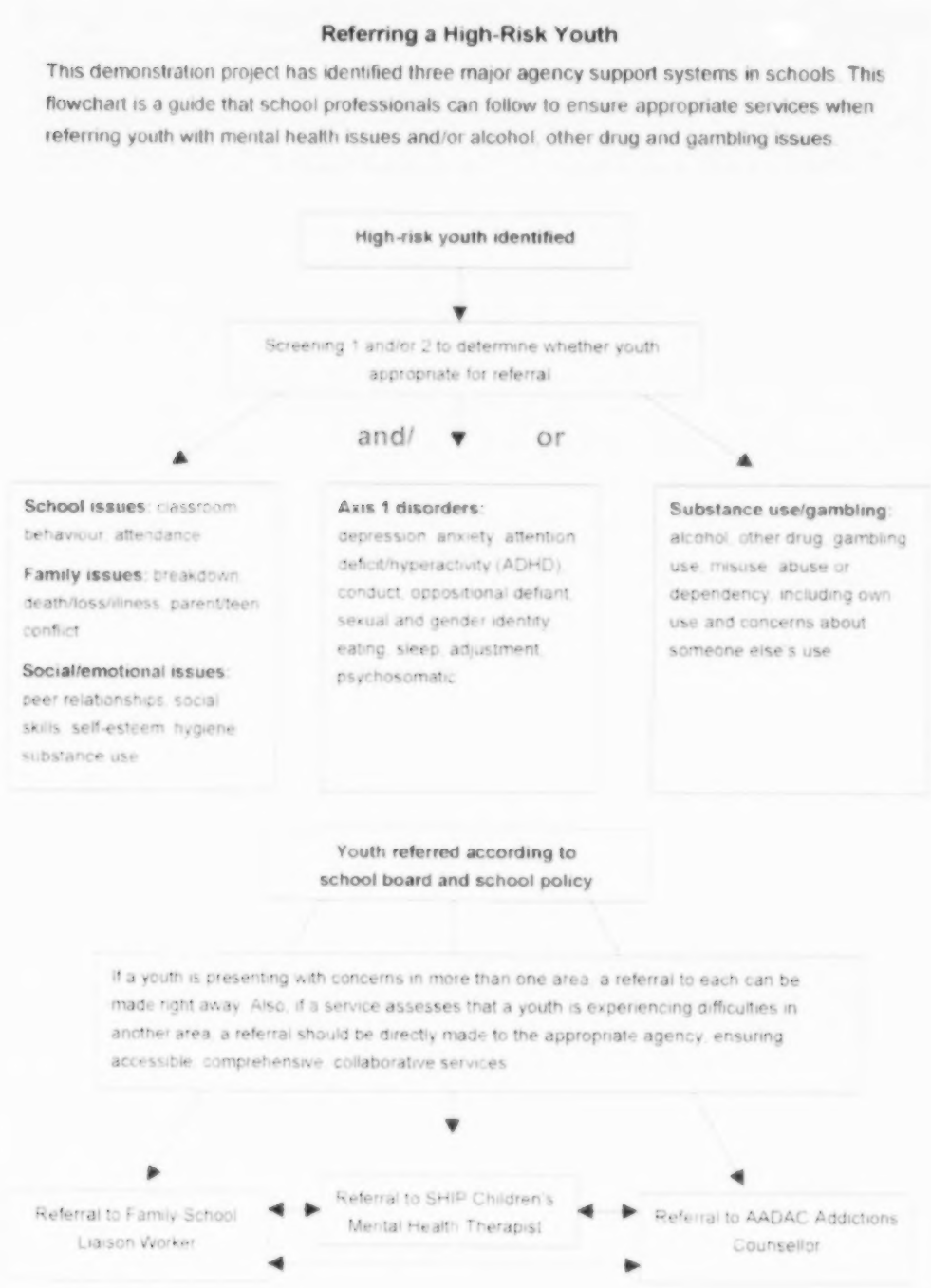


FIGURE 3: Referral Model (Fort McMurray Demonstration Project)


Referring a High-Risk Youth
This demonstration project has identified three major agency support systems in schools. This flowchart is a guide that school professionals can follow to ensure appropriate services when referring youth with mental health issues and/or alcohol, other drug and gambling issues.
High-risk youth identified
Screening 1 and/or 2 to determine whether youth appropriate for referral
and/
or
School issues: classroom behaviour, attendance
Family issues: breakdown, death/loss/illness, parent/teen conflict
Social/emotional issues: peer relationships, social skills, self-esteem, hygiene, substance use
Axis 1 disorders: depression, anxiety, attention deficit/hyperactivity (ADHD), conduct, oppositional defiant, sexual and gender identity, eating, sleep, adjustment, psychosomatic
Substance use/gambling: alcohol, other drug, gambling use, misuse, abuse or dependency, including own use and concerns about someone else's use
Youth referred according to school board and school policy
If a youth is presenting with concerns in more than one area, a referral to each can be made right away. Also, if a service assesses that a youth is experiencing difficulties in another area, a referral should be directly made to the appropriate agency, ensuring accessible, comprehensive, collaborative services.
Referral to Family School Liaison Worker
Referral to SHIP Children's Mental Health Therapist
Referral to AADAC Addictions Counsellor

Evaluation methods

Each demonstration project was evaluated to identify the findings from implementing elements of the provincial framework, including a collaborative care model for people with concurrent disorders.

The evaluations focused on (a) assessing the fidelity and effectiveness of the demonstration projects in implementing the provincial framework, (b) determining the quality of the services implemented by each demonstration project, and (c) making recommendations for future service delivery development and implementation at the regional and provincial levels. These were assessed at the systems, clinical practice and client level of service provision.

A qualitative multiple methods approach was undertaken in the evaluations. One-on-one interviews and focus groups; reviews of capacity building initiatives and resources, operational processes and other relevant documents; and critical assessments of documents in the literature were used to provide a comprehensive understanding of the provincial framework implementation.

Three reports were produced from the evaluation of the concurrent disorders demonstration projects:

1. *Building Capacity—A Framework for Serving Albertans Affected by Addiction and Mental Health Issues: Final Evaluation Report of the Edmonton Demonstration Project* (AADAC, 2006a)
2. *Building Capacity—A Framework for Serving Albertans Affected by Addiction and Mental Health Issues: Final Evaluation Report of the Fort McMurray Demonstration Project* (AADAC, 2006b)
3. *Building Capacity—A Framework for Serving Albertans Affected by Addiction and Mental Health Issues Demonstration Project Evaluations: System-Level Analysis Report* (AADAC, 2006c)

Key findings

Overview of the expected outcomes

The following table assesses the implementation of expected outcomes outlined for the two demonstration projects. Each expected outcome is rated according to whether the expected outcome was "met," had made "good progress" or had made "some progress."

Table 1. Assessment of the Expected Outcomes for the Implementation of the Two Demonstration Projects

Expected Outcomes	Met	Good Progress	Some Progress
1. Unmet needs of clients are identified.	√		
2. Seamless service is accessible to clients.		√	
3. Unique needs of clients with concurrent disorders are met.		√	
4. Roles of various service providers are articulated.		√	
5. Screening and assessment processes and protocols are refined.			√
6. A system of shared care is implemented.		√	
7. A range of flexible, person-centred treatment options is available to clients with concurrent disorders.		√	
8. An inventory of staff and program capacity is created.			*
9. Staff and program competencies are identified.			*
10. Clinical information is secure and appropriately available.			**

* No data were gathered on these dimensions.

** Client confidentiality is maintained according to existing protocols within both AADAC and Mental Health at both sites.

Thematic highlights of the key findings

Findings from the concurrent disorders demonstration projects are instructive to the two demonstration projects as well as to future concurrent disorders collaborative care endeavours. Key findings about what worked well and areas for improvement are grouped according to the following six themes:

1. Creating value and meaning for clients
   - determining the value of collaborative care models to clients with concurrent disorders
2. Building an understanding of concurrent disorders service delivery
   - understanding the processes of service delivery and client flow for addictions and mental health services
   - establishing working relationships and processes of service delivery between addictions and mental health services
3. Capitalizing on existing community and organizational structures and processes
   - identifying existing working relationships and community/organizational structures and processes to assist in effectively and efficiently implementing a concurrent disorders initiative
4. Building skills and capacity of service providers
   - professional development and capacity building, through activities such as training, cross-training, consultation and case management, to successfully implement a concurrent disorders initiative
5. Managing and supporting a concurrent disorders collaborative care model of service provision
   - communicating the processes of service delivery to staff and clients
   - establishing, managing and supporting a changed way of working together
6. Assessing the fidelity and effectiveness of the provincial framework
   - implementing elements outlined in the provincial framework
   - assessing the feasibility and effectiveness of implementing the framework elements
   - monitoring and tracking the implementation process through ongoing evaluation and performance measurement assessment

What worked well

Overall, the concurrent disorders demonstration projects showed that collaborative efforts between addictions and mental health services in providing concurrent care to clients were positive. Staff in both service provider organizations were eager and willing to continue the good work that had been accomplished to date. Generally, clients expressed a positive outlook on the service and treatment they were receiving, and management was encouraged by the progress made in implementing these demonstration projects.

The following section highlights some of the key findings that worked well with the implementation of the concurrent disorders demonstration projects.

Creating value and meaning for clients

Clients receiving concurrent addictions and mental health services in the Edmonton demonstration project indicated they felt accepted and understood, more knowledgeable about their concurrent disorders, and able to work on both their addictions and mental health issues at the same time. As such, they were hopeful about their treatment, and expressed no longer feeling or being alone. A few clients also indicated they had improved access to services and improved availability of information about concurrent disorders. Here are some of the verbatim client comments:

> *For the first time they are actually acknowledging the addiction and the mental illness...I am working on both things at the same time. (client)*

> *My counsellor didn't know I had PTSD. As soon as I told her the alarm bells went up and she said, "We are only treating one thing here." Ever since then...this time it's a whole lot better. It is a ray of hope.... Everything just makes more sense. This is the first time in my life things are happening together. I just increased my odds by 50% by doing this dual thing. (client)*

Clients indicated that their addictions counsellors and mental health therapists were important individuals in assisting them with their concurrent disorders. For example, in the Edmonton demonstration project:

- The counsellors and therapists could advocate on behalf of clients by helping them navigate the system of care linking clients to appropriate services, whether it was for counselling, mental health therapy or some other service.
- Clients appreciated having the name of a person (counsellor/therapist) when being referred to AADAC or mental health services. This personalized the process for them and made navigation through the system easier.
- Both AADAC and mental health services have ongoing programs for clients with concurrent disorders, and these are highly regarded by clients.

In the Fort McMurray project:

- Youth indicated that their addictions counsellors were important in helping them with their addictions issues.
- Providers indicated that clients received more co-ordinated, seamless service through improved screening and referral processes, as well as through increased capacity of staff to appropriately refer clients.
- Youth identified with the person versus the organization.

Access to on-site counselling was important for clients. Youth from the Fort McMurray project appreciated having access to on-site counselling in their schools during the day and did not report experiencing any stigma associated with accessing addiction services.

Building an understanding of concurrent disorders service delivery

Understanding how the addictions and mental health services will be provided concurrently to clients is an important element in establishing positive and efficient working relationships and developing services. The development of service delivery flow charts assisted addictions and mental health service providers in understanding each other's service delivery flow.

Management from each of the demonstration projects developed a flow chart of service provision. This visual display was a powerful mechanism to help facilitate the implementation of their respective collaborative care models. Project flow charts or models are visual representations of service provision that can help management and staff build an understanding of client flow and provider roles and responsibilities. They can illustrate how clients with concurrent disorders move through the system of care, and provide an understanding of the linkages whereby addictions and mental health systems can work together to support clients. Management found this a useful tool to co-ordinate and communicate collaborative service delivery.

Capitalizing on existing community and organizational structures and processes

Existing community agency partnerships and working relationships should be considered as ways of developing and enhancing a collaborative system of addictions and mental health care. Capitalizing on these existing relationships and infrastructure can assist in the implementation of a collaborative care system, thereby reducing fragmentation of service delivery and processes.

For example, in the Fort McMurray demonstration project, the Wood Buffalo Student Health Initiative Partnership (SHIP), a tri-ministry collaboration between Alberta Children's Services, Alberta Education and Alberta Health and Wellness, was an unexpected but beneficial linkage. Typically the SHIP network refers students with mild to moderate special needs to service providers within the SHIP network of providers. The advantage to service providers is that information can be shared among providers (through parental/guardian consent, standardized referral forms and information sharing processes) thereby eliminating repeat history gathering. Capitalizing on this kind of structure and working relationship can save both time and other resources, providing more co-ordinated services for clients.

Building skills and capacity of service providers

Enhanced support for consultation, case management and cross-agency meetings are necessary factors in building the skills and capacity of service

providers, and ideally result in an increase in appropriate referrals and system efficiencies. This also provides staff with opportunities for

- professional development
- learning about the work of other service providers (addictions and mental health)
- developing further collaborative working relationships and processes

On-site consultation helped counsellors and therapists gain familiarity with each other and their work on professional levels. In the Edmonton demonstration project, on-site consultation was identified as one of the most successful strategies for skill and capacity building. This provided professional consultation support and helped develop good relationships amongst practitioners. On-site consultation helped to build an understanding of each other's areas of expertise, and of how their respective roles were complementary in meeting clients' needs. In the Edmonton demonstration project, this led to increased levels of trust and confidence in both service provision and the collaborative care model.

Training and cross-training are also important professional development components in developing a concurrent disorders collaborative care model. Cross-trained individuals brought a valuable skill set to the demonstration project; therefore, cross-training is encouraged.[3] Skill and experience in partnering may become even more important considerations in future hiring processes for all service providers, because partnering and collaboration are reflected in AADAC's Business Plan, the Provincial Mental Health Plan and the Regional Mental Health Plan.

Managing and supporting a concurrent disorders collaborative care model of service provision

Attitudinal shifts about providing concurrent addictions and mental health care to clients did occur among service provider staff, partly because of organizational support for participating in the demonstration project, as well as the influence of early adopters in adopting and embracing new practices.

Early adopters played an integral role in the uptake of the new initiative and engaging others in the uptake. Early adopters are characterized as being self-confident in their skill sets, self-reflective and curious by nature, team players who are willing to expose their practice to others, open and able to recognize

[3] Research indicates that shared care models that effectively use the knowledge and skills of each professional require each team member to be aware of their role within the team and adequately communicate with other team members to prevent gaps and duplication in care (Can: Belle Brown et al., 2003; Hall, 2004; U.K.: Bower et al., 2003). Therefore, educational and training opportunities are important for all members participating in a collaborative model (Can: Belle Brown et al., 2003; Kasperski, 2004; U.K.: Graham, 2004; U.S.: Berman et al., 2000; Holleman et al., 2004; Hunter et al., 2005; Watkins et al., 2001). To facilitate successful education and training, funding for a training plan that is part of a larger human resources strategy (training and supervision, cross-training, continuing education, formal curricula development and credentialing) is required (Can: Health Canada, 2002a; 2002b).

that boundaries exist but that they are permeable. Learning about early adopters can help to improve implementation processes, and inform how to engage other counsellors and therapists who may be more reluctant to change attitudes and behaviours toward providing concurrent service for clients with addictions and mental health issues.

Assessing the fidelity and effectiveness of the provincial framework

No incongruence appeared between what the provincial framework espouses and what the demonstration projects experienced in implementation.

Results from the evaluations of both demonstration projects indicated that the provincial framework served as a "touchstone" to providers striving to put its concepts and principles into operation. Accordingly, the projects made good progress in implementing elements of the framework. There was no indication that the framework document should be changed.

Areas for improvement (barriers and limitations)

Clients, staff and management from each of the demonstration projects articulated areas for improvement for their own projects as well as considerations for other projects that may be implementing concurrent disorders initiatives.

Creating value and meaning for clients

Some of the barriers and limitations for clients in both the Edmonton and Fort McMurray demonstration projects related to access to counselling services. In particular, access to on-site counselling was important for clients. The Edmonton project clients wanted more access to on-site psychiatric counselling. The Fort McMurray clients wanted access to addictions counsellors more often and for longer periods of time. This indicates that resource capacity needs to be addressed when implementing a collaborative care service delivery model.

Clients who were aware of the interconnected working relationship between addictions and mental health services had a greater understanding and appreciation of how these two services were making a difference in their care. This was the case for the Edmonton demonstration project clients. The contrary was true for the Fort McMurray youth clients, who were more familiar with the addictions counsellors' role but were not fully aware of the mental health connection to their care. As a result, they were not aware of the linkage of services to their care. This could be attributed partly to the stage of development of this project; some of the service provision processes were in early developmental stages.

Building an understanding of concurrent disorders service delivery

Although management from each of the demonstration projects developed flow charts to illustrate the flow of clients within and between addictions and mental health services, staff were not fully aware of the flow charts, systems of client flow, and their specific roles and responsibilities in each concurrent disorders initiative. Increased awareness and involvement of front-line staff could have been facilitated by the use of visuals (as mentioned earlier) and by regular debriefings about how things were going and what could be improved. This would also facilitate learning and ongoing communications among staff and management.

Building skills and capacity of service providers

Language is meaning, and without common language, there is no shared understanding.[4] There were several examples in the demonstration projects where the technical language differed among service providers; this sometimes resulted in confusion and misunderstandings. Opportunities to communicate and document the language and terms used would be beneficial to ensure common understanding.

Internal assessment of training sessions AADAC provided to the Edmonton Mental Health Clinic therapists indicated high levels of satisfaction immediately following delivery of the sessions, although over time, satisfaction deteriorated. Motivational interviewing techniques and client engagement are priority topics for mental health therapists. It will be important to monitor what staff feel are their needs, and to respond to those identified needs.

Managing and supporting a concurrent disorders collaborative care model of service provision

Leadership style[5] facilitates the implementation of collaborative care models. Strong leadership to build, clarify and sustain roles and relationships[6] among service providers is a necessary element in a successful collaborative care

[4] Common language evolves with clarification of the various team members' roles and responsibilities (U.S.: Berman et al., 2000). That is, each team member must have a distinct and necessary role on the team (U.K.: Mickan & Roger, 2000). Each role is valued and team members should have equal status (Can: Hall, 2004). A common goal facilitates the development of common language and a common conceptual framework (Can: Belle Brown et al., 2003; Hall, 2004).

[5] The literature points out that strong champions or opinion leaders are essential to the ongoing progress and sustainability of collaborative care (U.S.: Drinka & Clark, 2000; Mueser et al., in press, as cited in Health Canada, 2002a). In fact, lack of clear leadership predicts low levels of effectiveness (U.K.: Mickan, 2005). Active leadership contributes to team climate and facilitates team problem solving and accountability (U.S.: Drinka & Clark, 2000).

[6] Relationship building is facilitated through inviting all relevant agencies to participate in the collaborative and keeping communication open; using mechanisms such as monthly meeting and training staff in activities of the other agency to create and maintain a shared knowledge base; and nurturing one-to-one relationships among service providers across service sectors (Aus: Sweeney & Kisely, 2003; U.K.: Bower et al., 2003; Williams & Laungani, 1999; U.S.: Hattori & Lapidus, 2003; Ridgely et al., 1998; Torrey et al., 2002).

model for people with concurrent disorders. One of the demonstration projects took on a less formal and visible leadership style in implementation. Senior management from this project indicated that a formal launch of the demonstration project activity, along with explanation of goals, purposes, timelines and milestones, may have helped engage more front-line staff and helped staff feel more informed and knowledgeable about the implementation of a concurrent disorders collaborative care model. In addition, staff from one of the demonstration projects indicated that the relationship building, co-ordination and development of the service provision resided and was discussed primarily at the management level with little or no involvement of the front-line staff. As a result, some staff felt disconnected from the project and suggested that in the future they need to be more closely involved. Thus, opportunities for relationship building at all levels between addictions and mental health services need to be nurtured and supported through time and resources.

Time and resources were identified as critical factors to build confidence in professional roles and establish working relationships in order to work collaboratively and successfully with other providers. As such, realistic expectations need to be set regarding how long it will take not only to get staff on board with a new initiative, but also to ensure that time, resources and leadership are available for professional development, relationship building, and opportunities to practise and implement skills and roles. This level of support from management is critical.

Although screening tools and shared consent forms were developed for the demonstration projects, of equal importance are the processes for service provider implementation and utilization. Staff may have been aware of screening tools and shared consent forms but may not have been consistently using these. This may have been because a new system was being implemented, staff were unwilling to change behaviour, or staff were unsure of how to appropriately integrate these new tools into their current practice. In any case, it is important to have continued and appropriate training and consultation to relay the importance of using the new tools and processes, and to clearly identify how staff should be using these new tools and incorporating these new processes. As mentioned previously, this is an area in which early adopters can contribute to change management within the organization.

Though the provincial framework is strongly supportive of information sharing across providers, key challenges (at both the project and system level) related to time, resources, client consent documentation and processes, and lack of capacity of existing information systems make it difficult to collect and share common client information among service providers. This can hinder effective case management within an otherwise effective collaborative care model. Systemic changes are needed to support further implementation of the model to ensure a more fluid movement of client case information between service providers.

Recommendations and implications

To enhance implementation processes and continue to move toward a successful collaborative care system, the following recommendations are offered:

1. Continue to provide support for refining screening tools that are easy for providers to use, brief, and non-intrusive on clients, especially during an intake interview.
2. Involve front-line counsellors and therapists in regular review exercises to share what is working and develop solutions for what could be improved.
3. Provide time and resources for counsellors and therapists to spend time at each other's workplace to gain an understanding of their roles and responsibilities, and to build personal relationships to facilitate referral and information sharing.
4. Support cross-training and professional development opportunities. Topics should include team building and leadership. Also explore with counsellors and therapists other topics that would be beneficial to their professional development and practice.
5. Consider increasing consultation availability, not only of AADAC consultants to mental health services and mental health consultants to AADAC, but also of psychiatrists at both agencies.
6. Support the development of client consent protocols and processes, which includes gathering of common client information that can be shared among service providers, and information systems that will accommodate the realities of collaborative care models.
7. Develop milestones and performance measures to facilitate ongoing monitoring and evaluation of the implementation and impact of collaborative care delivery models for services to people with concurrent disorders.
8. Continue to provide strong leadership at all levels (e.g., clinical practice and system organizational level) to support implementation of the Building Capacity provincial framework.
9. Continue to use the provincial framework as a template for developing new concurrent disorders initiatives or continuing to build on existing initiatives with addictions and mental health services.
10. Develop an orientation and training plan for staff to ensure they have a clear understanding of their roles, responsibilities and working processes.

The findings and recommendations highlighted in the evaluations of the two demonstration projects provide implications and considerations when additional concurrent disorders initiatives are implemented at a regional and provincial level. Some of these implications and considerations are identified as follows:

One of the key elements highlighted in the evaluation is the value of establishing processes and relationships between mental health and addictions services to ensure there is an understanding of roles and the process of client flow within and between service providers, along with active organizational endorsement.

Establishing these processes and clarifying and defining these roles and expectations takes time for full and successful adoption by both service providers. As such, a realistic understanding of the stage of development of these initiatives is necessary to assist in continued building and development of collaborative care models.

In terms of the linkages of concurrent disorders initiatives to the Building Capacity framework, there was evidence of alignment with the provincial framework. Future initiatives of this nature would need to continue to ensure that the framework elements are incorporated as fundamental components, and to clearly identify how these elements will be incorporated into service delivery.

Overall, the concurrent disorders demonstration projects identified a number of positive strategies that have been taken and can be taken to provide meaningful and supportive services to Albertans affected by addictions and mental health issues

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